STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

DUNGENESS COURTE ALZHEIMERS COMMUNI
DUNGENESS COURTE ALZHEIMERS COMMUNITY
651 N GARRY OAK DR
SEQUIM, WA 98382

RE: DUNGENESS COURTE ALZHEIMERS COMMUNITY License # 1328

Dear Administrator:

This letter addresses Compliance Determination(s) 36316 (Completion Date 01/31/2024) and 33825 (Completion Date 12/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/31/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2630-1, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1-b, RCW 70.129.140.1, WAC 388-78A-2660-2

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: DUNGENESS COURTE ALZHEIMERS COMMUNITY
License/Cert.#: 1328
Compliance Determination #: 33825
Investigator: Phan Pham
Investigation Date(s): 12/12/2023 through 12/27/2023
Complainant Contact Date(s): 12/15/2023

Provider Type: Assisted Living Facility

Intake ID: 108764
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Resident abuse - A staff member allegedly yelled at Named resident.

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 4 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Named resident, residents, and interdisciplinary team members.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An on-site investigation was conducted, and the concerns related to resident mistreatment, quality of care and treatments were reviewed. The assisted living facility failed to ensure a staff member treated a resident in a manner that maintained or enhanced the resident's dignity and respect. Additional residents reviewed for care, services and safety had no concerns.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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Statement of Deficiencies	License #: 1328	Compliance Determination # 33825
Plan of Correction	DUNGENESS COURTE ALZHEIMERS COMMUNITY	Completion Date
Page 1 of 5	Licensee: DUNGENESS COURTE ALZHEIMERS COMMUNI	12/27/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 12/12/2023, 12/12/2023 and 12/27/2023 of:

DUNGENESS COURTE ALZHEIMERS COMMUNITY
651 N GARRY OAK DR
SEQUIM, WA 98382

This document references the following complaint number(s): 108764

The following sample was selected for review during the unannounced on-site visit: 4 of 42 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

_____ 12/28/2023
Residential Care Services Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

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Administrator (or Representative) 1/4/24 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on observation, interviews and records review, the facility failed to ensure staff members reported an allegation of a staff member treating a resident in a manner that was lacking dignity and respect to the department's hotline for 1 of 4 sampled residents (Resident 1, R1). This failure placed Resident 1 at risk for not being treated with dignity and respect and a decrease in quality of life.

Findings included...

Review of R1's face sheet showed the resident was admitted to the facility on [redacted] 2022 with diagnoses including [redacted].

The resident assessment printed 12/12/2023 documented that R1 was independent with communication and hearing. The resident had a history of using inappropriate language toward staff. The resident's negotiated service plan dated 07/13/2023 documented R1 had a history of verbal outbursts, frequently angry with symptoms of hallucination. The negotiated service agreement had instructions to redirect R1 with conversation, okay to leave the resident's room and reapproach later.

Review of a witness statement from Caregiver (Staff B) documented on 12/03/2023 between 6:30 AM to 7:00 AM, Staff B was assisting R1's roommate and R1 yelled very loudly and repeatedly at Staff B to get out of his house. Caregiver (Staff C) heard the yelling and came to assist R1. R1 was using his walker incorrectly, out of bed, and Staff C attempted to assist R1 back to his side of the room.

Reviewed of Staff C's statement dated 12/03/2023 showed Staff C entered R1's room and

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observed the resident yelling, cursing, attempting to walk without his walker, and was unstable. Staff C redirected R1 and the resident headed back to his bed. Staff C stated out loud that the resident was acting like a "psycho" and the resident said, "Yeah, I am a psycho." Staff C told the resident that he could sit and talk to his voices.

Review of Caregiver's (Staff D) witness statement dated 12/03/2023 showed on 12/03/2023 at 7:00 AM, Staff D heard R1 yelling and went to the resident's room. Staff D witnessed Staff C grabbing R1's walker, yelled, "I am sick of your sh*t," and attempted to redirect the resident back to his bed. The resident was agitated and yelled repeatedly, "Get out of my house." Staff C yelled at R1 and told the resident, "You are a f**king psycho and go talk to your voices."

On 12/12/2023 at 10:18 AM, the resident was observed sitting on his bed and neatly groomed. In an interview the resident was not able to provide additional information related to the incident.

In an interview on 12/12/2023 at 10:19 AM, Director of Wellness (Staff A) said she received the report from Staff D on 12/03/2023. Staff A stated she was responsible for investigating and reporting to the State. Staff A said she investigated the allegation and did not report to the State because she did not suspect abuse or neglect.

In an interview on 12/12/2023 at 10:52 AM, Staff C said on 12/03/2023 she heard R1 was yelling repeatedly and went to his room. Staff C stated the resident was standing, did not have his walker and was unsteady on his feet. Staff C said she attempted to assist R1 to his bed and said out loud that "he's acting like a psycho."

In an interview on 12/13/2023 at 5:00 PM, Staff D said she heard R1 yelling and went into the resident's room. Staff D stated she witnessed Staff C telling R1, "I am sick of your sh*t. You are a f**king psycho and go talk to your voices." Staff D said she reported the incident to Staff A on 12/03/2023.

This is a recurring deficiency previously cited on 08/11/2021.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, DUNGENESS COURTE ALZHEIMERS COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 1/31/24.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

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Administrator (or Representative) 1/4/24 Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interviews and records review, the Assisted Living Facility (ALF) failed to ensure a staff member treated a resident in a manner that maintained or enhanced the resident's dignity and respect for 1 of 4 residents (Resident 1, R1). This failure placed Resident 1 at risk for being treated without dignity, respect, and a decrease in quality of life.

Findings included...

Review of R1's face sheet showed the resident was admitted to the facility on [redacted]2022 with diagnoses including [redacted].

The resident assessment printed 12/12/2023 documented R1 was independent with communication and hearing. The resident had a history of using inappropriate language toward staff. The resident's negotiated service plan dated 07/13/2023 documented R1 had a history of verbal outbursts, frequently angry with symptoms of hallucinations. The negotiated service agreement had instructions of redirecting R1 with conversation, okay to leave the resident's room and reapproach later.

Review of a witness statement, Caregiver (Staff B) documented on 12/03/2023 between 6:30 AM to 7:00 AM, Staff B was assisting R1's roommate and R1 yelled very loudly and repeatedly at Staff B to get out of his house. Caregiver (Staff C) heard the yelling and came to assist R1. R1 was using his walker incorrectly, out of bed, and Staff C attempted to assist R1 back to his side of the room.

Review of Staff C's statement dated 12/03/2023 showed Staff C entered R1's room and observed the resident yelling, cursing, attempting to walk without his walker, and was unstable. Staff C redirected R1 and the resident headed back to his bed. Staff C stated out loud that the resident was acting like a "psycho" and the resident said, "yeah, I am a

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On 12/12/2023 at 10:18 AM, the resident was observed sitting on his bed and neatly groomed. In an interview the resident was not able to provide additional information related to the incident.

In an interview on 12/12/2023 at 10:52 AM, Staff C said on 12/03/2023 she heard R1 was yelling repeatedly and went to his room. Staff C stated the resident was standing, did not have his walker and unsteady on his feet. Staff C said she attempted to assist R1 to his bed and said out loud that "He's acting like a psycho." Staff C said she had been trained to treat residents with dignity and respect and that was not a good thing to say to the resident.

In an interview on 12/12/2023 at 12:35 PM, Executive Director (Staff E) stated staff members had been trained to treat residents with dignity and respect. Staff E said management staff members were responsible for ensuring staff members treated residents with dignity and respect and she was available for staff to consult.

In an interview on 12/13/2023 at 5:00 PM, Staff D said she heard R1 yelling and went into the resident's room. Staff D stated she witnessed Staff C telling R1, "I am sick of your sh*t. You are a f**king psycho and go talk to your voices." Staff D said she had been trained to treat residents with respect and dignity.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, DUNGENESS COURTE ALZHEIMERS COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 1/31/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Deb Roth — 1/4/24

Administrator (or Representative) — Date

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